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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **DEBRA LYNN TAURMAN, AKA DEBBIE LYNN TAURMAN** **24143 Del Monte Drive, Unit 278** **Valencia, CA 91355** **Registered Nurse License No. 605739** Respondent.	Case No. 2011-430 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about September 3, 2002, the Board of Registered Nursing issued Registered Nurse License Number 605739 to Debra Lynn Taurman, aka Debbie Lynn Taurman (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2012, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Code provides in part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in the Nursing Practice Act.

5. Section 2764 of the Code provides in part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

6. Section 2811(b) of the Code provides in part, that the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

7. Section 2761 of the Code states in part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct."

8. Section 2762 of the Code states:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

"(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

. . . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

COST RECOVERY

9. Section 125.3 of the Code provides in part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCE / DANGEROUS DRUG

10. Morphine is a Schedule II controlled substance pursuant to Health and Safety Code section 11055(b)(1)(M), and is a dangerous drug pursuant to Code section 4022.

11. Dilaudid is the trade name for Hydromorphone, a Schedule II controlled substance pursuant to Health and Safety Code section 11055 subdivision (b)(1)(K), and a dangerous drug pursuant to Code section 4022.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

12. Respondent is subject to disciplinary action under section 2761, subdivision (a), on the grounds of unprofessional conduct, in that Respondent, while employed with UCLA Medical Center and Orthopaedic Hospital, withdrew medication from Pyxis[1], without a physician's order, in an amount that exceeded the physician's order or withdrew medication for patients for which she was not the primary nurse. The circumstances are as follows:

[1] Pyxis is a trade name for the automatic single-unit dose medication dispensing system that records information such as patient name, physician orders, date and time medication was withdrawn, and the name of the licensed individual who withdrew and administered the medication. Each user is given a user identification code to operate the control panel. Sometimes only portions of the withdrawn medication are given to the patient. The portions not given to the patient are referred to as "wastage." This waste must be witness by another authorized user and is also recorded by the Pyxis machine.

a. On January 6, 2008, a physician ordered 2mg of Dilaudid for Patient 1[2], Respondent withdrew 4mg of Dilaudid, and recorded the administration of 2 mg of Dilaudid to Patient 1. Respondent did not record the wastage of the remaining 2 mg.

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b. On December 31, 2007, a physician ordered Morphine 2mg IM for Patient 2.[3] Respondent withdrew 4mg of Morphine, and recorded the administration of 2mg of Morphine to Patient 2. Respondent did not record the wastage of the remaining 2mg.

c. On December 29, 2007, Respondent withdrew 4mg of Morphine, without a physician's order and recorded the administration of 2mg of Morphine to Patient 3.[4] Respondent did not record the wastage of the remaining 2mg.

d. On December 29, 2007, a physician ordered 2mg of Morphine for Patient 4.[5] Respondent withdrew 10mg of Morphine, and recorded the administration of 2mg of Morphine to Patient 4. Respondent did not record the wastage of the remaining 8mg.

e. On November 29, 2007, a physician ordered Morphine 2mg IVP for Patient 5.[6] Respondent withdrew 4mg of Morphine, and recorded the administration of 2mg of Morphine to Patient 5. Respondent did not record the wastage of the remaining 2mg.

f. On November 28, 2007, a physician ordered Dilaudid 2mg IV and Dilaudid 2mg for Patient 6.[7] Respondent withdrew 4mg of Dilaudid IV and 4mg of Dilaudid. Respondent recorded the administration of 2mg of Dilaudid IV and 2mg of Dilaudid to Patient 6. Respondent did not record the wastage of the remaining 2mg of Dilaudid IV and 2mg of Dilaudid.

g. On November 28, 2007, a physician ordered 4mg of Morphine for Patient 7.[8] Respondent withdrew 10mg of Morphine. There is no record that Respondent administered the

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[2] Patient 1 can be identified by Medical Record ID # 026203221786005.
[3] Patient 2 can be identified by Medical Record ID # 026383439436001.
[4] Patient 3 can be identified by Medical Record ID # 026354471356005.
[5] Patient 4 can be identified by Medical Record ID # 026383427626001.
[6] Patient 5 can be identified by Medical Record ID # 026156266416033.
[7] Patient 6 can be identified by Medical Record ID # 026183722926008.
[8] Patient 7 can be identified by Medical Record ID # 026382659486001.

4mg of Morphine to Patient 7. Respondent did not record the wastage of the 6mg or 10mg of Morphine.

h. On November 20, 2007, a physician ordered Morphine 4mg for Patient 8.[9] Respondent withdrew 10mg of Morphine, and recorded the administration of 4mg of Morphine to Patient 8. Respondent did not record the wastage of the remaining 6mg. Approximately two hours later Respondent wasted 4mg of Morphine, but failed to record the wastage of the outstanding 2mg of Morphine.

i. On November 20, 2007, a physician ordered Morphine 4mg IV for Patient 9.[10] Respondent withdrew 10mg of Morphine. She was not the primary nurse for Patient 9. Respondent did not record the administration of 4mg to Patient 9. Respondent did not record the wastage of the remaining 6mg or 10mg of Morphine. Approximately three hours later Respondent wasted 6mg of Morphine. Respondent did not record the administration or wastage of the remaining 4mg.

j. On November 20, 2007, Respondent withdrew 10mg of Morphine, without a physician's order, for Patient 10.[11] Approximately three minutes after withdrawing the medication, Respondent returned the Morphine to stock. Respondent then withdrew 4mg of Dilaudid for Patient 10, when the physician's orders called for 2mg. Respondent was not the primary nurse for Patient 10. Respondent did not record the administration of 2mg of Dilaudid to Patient 10. Approximately, an hour and a half later, Respondent recorded the wastage of 2mg of Dilaudid. Respondent did not record the administration or wastage of the remaining 2mg.

k. On November 17, 2007, a physician ordered Morphine 4mg IV for Patient 11.[12] Respondent withdrew 10mg of Morphine. Respondent recorded the administration of 8mg of Morphine to Patient 11, which is 4 mg more than the physician ordered. Respondent did not record the wastage of the remaining 2mg.

[9] Patient 8 can be identified by Medical Record ID # 026252654306004.
[10] Patient 9 can be identified by Medical Record ID # 026080219416010.
[11] Patient 10 can be identified by Medical Record ID # 026352074896005.
[12] Patient 11 can be identified by Medical Record ID # 026078249316012.

l. On November 6, 2007, a physician ordered 2mg of Morphine for Patient 12.[13] Respondent withdrew 4mg of Morphine. Respondent recorded the administration of 2mg of Morphine to Patient 12. Respondent did not record the wastage of the remaining 2mg.

m. On November 6, 2007, a physician ordered 2mg of Morphine for Patient 13.[14] Respondent withdrew 4mg of Morphine. Respondent recorded the administration of 2mg of Morphine to Patient 13. Respondent did not record the wastage of the remaining 2mg.

SECOND CAUSE FOR DISCIPLINE

(False or Grossly Incorrect Medical Records)

13. Respondent is subject to disciplinary action under section 2762, subdivision (e), on the grounds of unprofessional conduct, in that Respondent made false or grossly incorrect entries in the UCLA Medical Center hospital records for Patient's 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 and 12, by withdrawing medication from the Pyxis system under the name of Patients for whom there was no physician's order; failed to record the administration of medication to the Patient for whom the medication was prescribed; recorded the administration of medication in an amount that exceeded a physician's order and or for whom Respondent did not document the administration or wastage of the drugs. Complainant's allegations as set forth in paragraph 12, subparagraphs (a) through (m), are incorporated by reference as though fully set forth.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Obtain / Possession of Controlled Substances)

14. Respondent is subject to disciplinary action under section 2762, subdivision (a), on the grounds of unprofessional conduct, in that Respondent unlawfully obtained and possessed controlled substances. Complainant's allegations as set forth in paragraph 12, subparagraphs (a) through (m), are incorporated by reference as though fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Use of Controlled Substance / Dangerous Drug)

[13] Patient 12 can be identified by Medical Record ID # 02632928126014.
[14] Patient 13 can be identified by Medical Record ID # 026247953796007.

15. Respondent is subject to disciplinary action under section 2762, subdivision (b), on the grounds of unprofessional conduct, in that Respondent used controlled substances and or dangerous drugs to an extent or manner dangerous to herself or others. Respondent told her supervisor that she used Morphine and Dilaudid.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 605739, issued to Debra Lynn Taurman, aka Debbie Lynn Taurman;

2. Ordering Debra Lynn Taurman, aka Debbie Lynn Taurman to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: 11/9/10

for LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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